Supreme Court, U.S.
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No.

In The

Supreme Court of the United States

October Term, 1997

TERESA KILLIAN,

Petitioner,

vs.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Is long term disability benefit plan which provides: "*Special provisions apply to disabilities caused by mental or nervous disorders, alcoholism or drug addiction. Benefits will be paid for a maximum of 24 months except if you are confined in a hospital at the end of that 24 month period, monthly benefits will be payable during the remainder of that confinement.*", and which does not define "special provisions", "caused by", or "mental or nervous disorders" ambiguous as a matter of law with regard to disabilities caused by physical problems and diseases?

Is a breach of fiduciary duty claim under ERISA precluded if another viable ERISA claim exists?

TABLE OF CONTENTS

	Page
Questions Presented	i
Table of Contents	ii
Table of Citations	iii
Opinions Below	1
Jurisdictional Statement	1
Statutes Involved	1
Statement of the Case	3
Reasons for Granting the Writ	13
Argument	14
A Long Term Disability Insurance Policy Which Provides: "*Special Provisions Apply to Disabilities Caused by Mental or Nervous Disorders, Alcoholism or Drug Addiction. Benefits Will Be Paid For a Maximum of 24 Months Except If You Are Confined in a Hospital at the End of That 24 Month Period, Monthly Benefits Will Be Payable During the Remainder of That Confinement.*", and Which Does Not Define "Special Provisions", "Caused By", or "Mental or Nervous Disorders" is Ambiguous as a Matter of Law with Regard to Disabilities Caused by Physical Problems and Diseases.	14

Contents

Page

A Breach of Fiduciary Duty Claim Under ERISA is Not Precluded if Another Viable ERISA Claim Exists. 23

Conclusion 25

TABLE OF CITATIONS

Cases Cited:

American and Foreign Ins. Co. v. Tee Jays Manufacturing Co., Inc., Tee Jays Holding Corporation, 1997 WL 187099 (Ala. 1997) 22

Forsyth v. Humana, Inc., 99 F.3d 1504 (C.A.9 1996) 24

Kunin v. Benefit Trust Life Insurance Co., 910 F.2d 534 (C.A.9 1989) 20

Lang v. Long Term Disability Plan, 125 F.3d 794 (C.A.9 1997) 21

Lynd v. Reliance Standard Life Ins. Co., 94 F.3d 979 (5th Cir. 1996) 14, 15, 19

Marecek v. BellSouth Services, Inc., 49 F.3d 702 (11th Cir. 1995) 22

Phillips v. Lincoln National Life Ins. Co., 978 F.2d 302 (C.A.7, 1992) 19

Contents

Page

Short v. American Cast Iron Pipe Co., 961 F. Supp. 261 (N.D. Ala. Mar. 26, 1997) 10, 23

Varity Corporation v. Howe, 116 S. Ct. 1065 (1996) 13, 23

Wald v. Southwestern Bell Corp., 83 F.3d 1002 (C.A.8 1996) 24

Statutes Cited:

28 U.S.C. § 1254(1) 1

29 U.S.C. § 101, *et seq.* 13

29 U.S.C. § 1104(a)(1) 1

29 U.S.C. § 1109(a) 2

29 U.S.C. § 1132(a)(3) 3

Rule Cited

Supreme Court Rule 10.1(c) 1

APPENDIX

Appendix A — Opinion of the United States Court of Appeals for the Eleventh Circuit Filed January 9, 1998 ..... 1a

Contents

Page

Appendix B — Judgment of the United States District Court, Northern District of Alabama, Middle Division, Filed February 21, 1997 ..... 9a

Appendix C — Findings of Fact and Conclusions of Law Filed February 21, 1997 ..... 10a

Appendix D — Opinion of the United States Court of Appeals for the Eleventh Circuit Filed February 25, 1998 ..... 17a

Appendix E — Motion for New Trial or Judgment Notwithstanding the Verdict Filed March 7, 1997 ..... 19a

Petitioner Teresa Killian respectfully petitions for a writ of certiorari to review the judgment of the Eleventh Circuit Court of Appeals regarding termination of long term disability benefits under an ERISA benefit plan.

OPINIONS BELOW

The District Court opinion and the opinion of the Eleventh Circuit Court of Appeals are unreported.

JURISDICTIONAL STATEMENT

The case to be reviewed is *Killian v. Provident Life and Accident Insurance Company*, (unreported, January 9, 1998) (App. A). Petition for rehearing was denied February 25, 1998 (App. D). The District Court judgment (February 21, 1997) is Appendix B with the memorandum opinion as Appendix C. The District Court denied a request for reconsideration (March 7, 1997) (App. E).

This Court has authority for this review under 28 U.S.C. § 1254(1) and Rule 10.1(c), Rules of the Supreme Court.

STATUTES INVOLVED

29 U.S.C. § 1104(a)(1) — Fiduciary Duties.

(a) Prudent man standard of care

(1) Subject to sections 1103(e) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and —

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

29 U.S.C. § 1109(a) — Liability for Breach of Fiduciary Duty

(a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting

from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary. A fiduciary may also be removed for a violation of section 1111 of this title.

29 U.S.C. § 1132(a)(3) — Civil Enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought —

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

STATEMENT OF THE CASE

Teresa Killian was employed as a technical writer at Southern Company Services. She began collecting long term disability benefits through Southern's health plan in September 1993 after suffering complications with a pregnancy. The Long Term Disability Plan provided that Killian would receive benefits for up to two years for any disability that prevented her from performing each and every duty of her job. Benefits were to continue after the two-year period only if Killian was unable to engage in any occupation for which she was reasonably qualified by training, education, and experience. Further, the plan provided that, for disabilities caused by mental or nervous disorders, benefits would be paid for only two years. (App. A — p. 2a).

The plan specifically provided:

> *Special provisions apply to disabilities caused by mental or nervous disorders, alcoholism or drug addiction. Benefits will be paid for a maximum of 24 months except if you are confined in a hospital at the end of that 24 month period, monthly benefits will be payable during the remainder of that confinement.*

(R3-17-19-6; R5-Ex 19-6). The plan did not define "special provisions", "caused by", or "mental or nervous disorders".

LTD benefits were originally paid by Teresa Killian's employer. On March 1, 1995, Provident Life and Accident Insurance Company (Provident) became the administrator and the insurer of the LTD benefit plan. Provident undertook responsibility for paying Plaintiff's future benefits (App. A, p. 2a; App. C, pp. 12a-13a, R5-Ex. 21). In accepting the liability of LTD claims of the employer, Provident performed a liability takeover analysis which listed Teresa Killian at age 36 with gross monthly disability benefits of $1,756.80. In the analysis, there was no mention of a 2-year limitation or any limitation based on a mental or nervous disorder. (R5-33-95; R5-Ex. 21).

On June 12, 1995, at Provident's request, Provident received proof of continuance of disability of Plaintiff, from Plaintiff and her treating physician, Dr. Warren-Lynch (R3-17-7; R5-Ex. 7).

On July 26, 1995, forty-four days later, Provident again wrote Dr. Warren-Lynch for an update on Plaintiff's condition (R3-17-8; R5-Ex. 8). Provident made repeated attempts to obtain current medical advice from Petitioner's attending physician, Dr. Warren-Lynch. These attempts were unsuccessful (App. A, p. 3a; App. C, p. 13a).

On November 2, 1995, Provident informed Petitioner that it wished to exercise the provision of the SCS Long Term Disability Plan allowing for a physical examination by someone other than Plaintiff's attending physician. Professional Appointment Services was hired to select a board-certified internist (App. C — p. 13a). No specific provision exists in the LTD Plan or the formal Plan document for such a physical examination (R3-17-19, 20; R5-Exs. 19, 20).

The exam lasted 15-20 minutes and consisted of checking Petitioner's eyes, ears, nose, throat, reflexes. The doctor listened to Petitioner's heart and had her walk a line and squat (R5-33-14). Dr. Kulback, the selected physician, believes the exam lasted 30 minutes (R5-33-34).

Dr. Kulback determined that Petitioner was able to perform some occupations for which she was reasonably qualified. In making this determination, Dr. Kulback noted that Petitioner had a medical history that included seizures, migraine headaches, mitral regurgitation, ulcers, bronchitis, sinusitis, staph infections, and depression. He stated in his December 1, 1995 report,

> I did not find any physical reasons why [Petitioner] would be unable to return to work on at least a limited basis in a job that did not require more than moderate physical activity. She does not appear to be eager to return to work, and in her correspondence with the insurance company and with physicians she reiterates many reasons why she should not return to work. . . . However, the **cumulative effect of these [physical] problems has certainly affected her psychologically, and it is certainly possible that her mental health status may prevent her from returning to gainful employment.**

(App. C, pp. 13a-14a).

After receiving the report from Dr. Kulback and receiving no response from the treating physician, Provident terminated long term disability benefits by letter of March 7, 1996, with an effective date of termination of September 14, 1995 (R-Excerpt 28-5; R3-17-10; R5-Ex. 10). The letter of March 7, 1996 was the first notice to Petitioner that Dr. Warren-Lynch, the treating physician, was not cooperating and not responding to Provident (R3-17-1; R5-Ex. 1; R5-33-19).

By letter dated April 7, 1996, Petitioner wrote to Provident advising Provident that Dr. Warren-Lynch had been out of the office nine (9) weeks on a medical leave of absence (R3-17-12; R5-12). Petitioner attached letters from Dr. Mihelic (4/4/96) and Dr. Pacifico (4/23/96) regarding her condition, and a copy of the Social Security decision (R5-Ex. 4) dated 11/21/94 awarding her Social Security disability benefits (R5-33-19). Dr. Pacifico stated that Plaintiff had numerous problems including recurrent fluid retention which requires therapy with Lasix. Dr. Mihelic stated that Plaintiff suffered from multiple medical problems, including chronic back pain, congestive heart failure, heart surgery for mitral regurgitation, anticipated heart surgery in the future, seizure disorder, juvenile myoclonic epilepsy, peptic ulcer disease, hiatal hernia, gastroesophageal reflux disease, irritable bowel syndrome, depression, frequent sinus problems, rheumatoid arthritis and migraine headaches.

Her current medications were Depakote, Micro-K, Serzone, Fossimax, Premarin, Prilosec, Lasix, Phentermine, Oxycodone, Hydrocodone, Roxicet, Unilax, Fibercon, Aspirin, Imitrex (for migraines), and Midrin (for migraines).

The Social Security Disability Award was based on the following finding:

> The claimant's impairments which are considered to be "severe" under the Social Security Act are major depression; generalized anxiety disorder; dependent personality disorder; juvenile myodonic [sic] epilepsy; headaches; rheumatic valvular heart disease; bronchitis; and a history of hiatal hernia, multiple heart catheterization, S/P mitral valve repair, and peptic ulcer disease.

After receiving said information, Provident reaffirmed the termination of LTD benefits by letter of May 8, 1996 and stated that Petitioner had **failed to provide medical evidence** that she was qualified for disability benefits and the appeal time had expired. (Emphasis supplied.) (App. C, p. 14a).

The official position of Provident is that after an appeal is filed from the administrator's denial and a decision is made on the appeal, no subsequent medical records will be considered (R5-33-103).

Petitioner's primary treating physician, Dr. Warren-Lynch, left the practice of medicine and was never available to provide information on Petitioner's condition.

Petitioner's position was always that she was totally disabled from physical problems and diseases, and that any mental or nervous disorder she experienced was caused by underlying physical problems.

After exhausting administrative remedies, Petitioner filed a lawsuit for benefits and for breach of fiduciary duty (R-Excerpts 1), and an amended complaint regarding fiduciary duty (R-Excerpts-20). The claim for breach of fiduciary duty was summarized in Petitioner's appellate brief as follows:

a. Defendant sent Plaintiff for a new evaluation shortly after she was awarded Social Security Disability;

b. Defendant requested updated information from Dr. Warren-Lynch on July 31, 1995, which was only 1½ months from receiving proof of continuance of disability from Dr. Warren-Lynch on June 12, 1995;

c. Defendant did not notify Plaintiff of the requests for updated information sent to Dr. Warren-Lynch on July 31, 1995 and January 1996;

d. Defendant terminated Plaintiff's benefits on March 7, 1996 on the basis of one brief examination by a non-treating physician, and because Dr. Warren-Lynch did not respond to requests for information when she was on a medical leave of absence.

e. Defendant assumed a strong adversarial role against Plaintiff when its duty is to work solely in the interest of Plaintiff.

Because there was no discretionary language in the Plan, the District Judge applied the *de novo* standard of review (App. C, p. 15a). The District Court ruled that benefits were properly terminated (App. C, p. 15a), that the terms of the Plan were clear (App. C, p. 15a), and that the Plan provided for two years of benefits for disabilities caused by mental disorders (App. C, p. 11a, 15a).

> [T]he plan provides that for disabilities caused by mental or nervous disorders, benefits would be paid only for two years.

(App. C, p. 11a)

Under a *de novo* standard of review, defendants's [sic] termination of plaintiff's long-term disability benefits is not due to be overturned. Under a *de novo* standard, the court focuses on the terms of the plan and other manifestations of the partes' [sic] intent. *Firestone Tire and Rubber v. Bruch*, 489 U.S. 101, 112-13 (1989); *Bedinghaus v. Modern Graphic Arts*, 15 F.3d 1027, 1029 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 426 (1994). Where disputed terms are without ambiguity, the court presumes that the natural meaning of the terms is conclusive evidence of the intent of the parties. *Bedinghaus*, 15 F.3d at 1029.

Under the clear terms of the plan, plaintiff's benefits were due to be ended on September 13, 1995 (two years after they began) because her disability resulted from a mental or nervous disorder. Further, all available medical evidence indicates that there was no physical reason why plaintiff would have been unable to engage in an occupation for which she was reasonably qualified.

Plaintiff has failed carry out [sic] her duty under the plan of furnishing certification by a physician that there was a physical reason for her disability, and has failed to show that she was unable to engage in an occupation for which she was reasonably qualified. Thus plaintiff has failed to propose any set of facts allowing her to be covered under a reasonable interpretation of this plan. *Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield of Alabama*, 41 F.3d 1476, 1481 (11th Cir. 1995), *cert. denied*, 115 S. Ct. 2002 (1995); *Brown v. Blue Cross and Blue Shield of Alabama*,

> 898 F.2d 1556, 1567 (11th Cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

(App. C, pp. 15a-16a).

The District Court ignored the breach of fiduciary claim and failed to adjudicate the claim. The District Court did not acknowledge the claim in the final judgment (App. C). In a subsequent ERISA decision of *Short v. American Cast Iron Pipe Co.*, 961 F. Supp. 261, 266 (N.D. Ala. Mar. 26, 1997), Judge Lynne, the same District Judge, explained that a breach of fiduciary duty claim was not available under ERISA if another viable ERISA claim exists:

> There are significant factual differences between *Varity* and this case that make relief under § 502(a)(3) inappropriate in the case sub judice. Specifically, this plaintiff was, at the time of the actions in question, a participant in a fully solvent plan. Thus § 502(a)(1)(B) allows him to recover any benefits he is due under the plan, and relief under § 502(a)(3) is not appropriate. The fact that plaintiff has voluntarily dismissed his claim for benefits under § 502(a)(1)(B) is not enough to make relief under § 502(a)(3) appropriate. To trigger recovery under § 502(a)(3), the ERISA statute must, as in Varity, fail to remedy all of the wrongs that were done to plaintiff. *Varity*, __ U.S. at __, 116 S. Ct. at 1079.

The Eleventh Circuit Court of Appeals, without citing any authority, ruled that the District Court's conclusion that the administrative termination of benefits was proper made it unnecessary to adjudicate Killian's fiduciary duty claim.

> Killian's final claim is that Provident breached its fiduciary duty to her when it ordered an independent examination of her condition and terminated her benefits. The district court's conclusion that the administrator's termination of benefits was proper made it unnecessary for it to reach Killian's fiduciary duty claim.

(App. A, p. 7a-8a).

Regarding ambiguity of the plan because of the undefined term "mental disorder", the Eleventh Circuit adopted the rule from the Fifth Circuit that said term is not ambiguous. The Court also stated that Appellant argued that a mental disorder with physical symptoms should not be included as a mental disorder:

> Even if Killian had adequately proven her disability, her benefits would still have been properly terminated subject to the plan's two-year limitation on "mental and nervous disorders." ER-28-7. Killian argues, however, that this limitation is ambiguous because "mental and nervous disorders" are never defined anywhere in the plan. **It is unclear, she claims, whether a disorder with a mental origin**[1]

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1. The Eleventh Circuit misstated Appellant's argument in such a way as to undermine Appellant's position. Appellant argued that physical problems caused whatever mental or nervous disorder which she had:

> Plaintiff's interpretation of said provision is that the two-year limitation does not apply if the mental or nervous disorders are caused by physical problems. It is Plaintiff's position that she is disabled due to physical problems which have caused some mental and nervous disorders. The physical problems are the cause of the disability.

(Appellant's brief, p. 29).

but physical symptoms, such as her somatization/ conversion disorder, falls within the two-year limitation. Had the district court properly recognized this ambiguity, Killian argues, it would have been forced to resolve the ambiguity in her (the insured's) favor. [Emphasis supplied.]

Lynd v. Reliance Standard Life Ins. Co., 94 F.3d 979 (5th Cir. 1996) is instructive. *Lynd* held that qualifying phrases such as " 'mental or nervous disorders' used in ERISA plans . . . should be accorded their ordinary, lay meanings." *Id.* at 983 (quoting *Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990). The Fifth Circuit reasoned that ERISA language is targeted to laypersons, not medical experts. We agree. The terms used to explain benefit limitations should be read through the lens of a layperson assessing the origin of an illness. There is no ambiguity.

Killian's disability is best classified as a "mental or nervous disorder." To hold that Killian's disability falls outside of the term "mental disorder" because it has "physical" symptoms would render the term "mental disorder" obsolete in this context. *Lynd*, 94 F.3d at 984. Provident cannot have intended for the two-year limitation to reach "only those [mental] illnesses, if there are any, which have no physical manifestations." *Id.* The fact that Killian's psychological disorder necessarily includes physical symptoms cannot render the disability a physical one rather than a mental one. Killian's entitlement to benefits had already lapsed by the time Provident notified her of the termination.

(App. A, pp. 6a-7a).

Federal jurisdiction exists because ERISA 29 U.S.C. § 101, *et seq.* authorizes federal preemption of benefit plans provided by employers.

REASONS FOR GRANTING THE WRIT

The writ should be granted because the Eleventh Circuit has entered a decision in conflict with decisions issued by the Seventh and Ninth Circuits regarding the term "mental disorder" as creating an ambiguity in an ERISA benefit plan. A conflict exists among the circuits regarding whether the undefined term "mental disorder" as an exclusion or limitation of health insurance, creates an ambiguity in an insurance policy or ERISA plan.

The writ should be granted because the decision conflicts with the United States Supreme Court decision in *Varity Corporation v. Howe*, 116 S. Ct. 1065 (1996). The Eleventh Circuit, along with the Eighth Circuit and the Ninth Circuit, have precluded said claims if another viable ERISA claim exists. The Eleventh Circuit has specifically held that a breach of fiduciary duty need not be considered if the ERISA benefit claim is denied. *Varity* places no such limitations on breach of fiduciary claims.

Such a rule would be fundamentally unfair because the breach of fiduciary duty often jeopardizes the claimant's ability to present his claim. Thus, a claimant may be denied benefits. However, if the fiduciary duty had not been breached, benefits would have been awarded. In such a situation, the benefit claim is not a "viable claim" and should not preclude a breach of fiduciary duty claim.

ARGUMENT

A LONG TERM DISABILITY INSURANCE POLICY WHICH PROVIDES: "*SPECIAL PROVISIONS APPLY TO DISABILITIES CAUSED BY MENTAL OR NERVOUS DISORDERS, ALCOHOLISM OR DRUG ADDICTION. BENEFITS WILL BE PAID FOR A MAXIMUM OF 24 MONTHS EXCEPT IF YOU ARE CONFINED IN A HOSPITAL AT THE END OF THAT 24 MONTH PERIOD, MONTHLY BENEFITS WILL BE PAYABLE DURING THE REMAINDER OF THAT CONFINEMENT.*", AND WHICH DOES NOT DEFINE "SPECIAL PROVISIONS", "CAUSED BY", OR "MENTAL OR NERVOUS DISORDERS" IS AMBIGUOUS AS A MATTER OF LAW WITH REGARD TO DISABILITIES CAUSED BY PHYSICAL PROBLEMS AND DISEASES.

The Eleventh Circuit held that the undefined term "mental disorder" was not ambiguous:

> *Lynd v. Reliance Standard Life Ins. Co.*, 94 F.3d 979 (5th Cir. 1996) is instructive. *Lynd* held that qualifying phrases such as " 'mental or nervous disorders' used in ERISA plans . . . should be accorded their ordinary, lay meanings." *Id.* at 983 (quoting *Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990). The Fifth Circuit reasoned that ERISA language is targeted to laypersons, not medical experts. We agree. The terms used to explain benefit limitations should be read through the lens of a layperson assessing the origin of an illness. There is no ambiguity. (Appellate Decision, pp. 6-7).

The Eleventh Circuit had not previously addressed such issue and relied upon the *Lynd* decision from the Fifth Circuit

which was a 2-1 decision with a strong dissent. The dissent in *Lynd* states the view of the Seventh and Ninth Circuits. The dissent very articulately states:

> It is well settled in this Circuit and a majority of the federal courts that, in construing the language of ERISA plans, federal law must follow the rule of contra proferentem, which directs that when plan terms remain ambiguous after applying ordinary principles of contract interpretation, courts are to construe them strictly in favor of the insured.

94 F.3d 979, 985.

> Because the rule that exceptions, exemptions, exclusions, provisions and limitations affecting coverage are construed strictly against the insurer is inherent within the rule of contra proferentem and consistent with congressional policy concerns, it should be recognized as part of the federal common law of rights and obligations under ERISA regulated plans.

Id. at 988.

> The term "total disability due to mental or nervous disorders" in the group long-term disability policy is ambiguous because it is susceptible to a number of reasonable interpretations. Clearly, a policy limitation on benefits due to mental illness or disorder is reasonably open to the construction that the total disability must have been caused purely by a behavioral disturbance with no demonstrable organic or physical basis. *See Phillips v. Lincoln Nat. Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992) ("mental illness"

limitation of ERISA plan was ambiguous as applied to participant suffering from congenital encephalopathy caused by organic illness; "mental illness" may with reason refer only to illnesses with non-physical causes such as those traceable to abuse suffered in childhood or other traumatic experiences such as divorce or bereavement or to a state of being psychotic or out of contact with reality when there is no accepted organic basis for the condition); *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir.), *cert. denied*, 498 U.S. 1013, 111 S. Ct. 581, 112 L. Ed. 2d 587 (1990) (upheld finding that autism was not a mental illness under an ERISA plan because the term refers to a behavioral disturbance with no demonstrable organic or physical basis); *Malerbi v. Central Reserve Life of North America Ins. Co.*, 225 Neb. 543, 407 N.W.2d 157 (Neb. 1987) (affirming finding that a mental illness limitation did not apply to behavioral abnormalities caused by organic brain defect); *Arkansas Blue Cross & Blue Shield, Inc. v. Doe*, 22 Ark. App. 89, 733 S.W.2d 429 (1987) (because the cause of manic-depressive disease was organic, it was not subject to insurance policy's mental illness limitation).

Other reasonable persons believe, however, that mental illness or mental disorder insurance limitations apply to any abnormal condition that manifests itself in symptoms that an untutored layperson without benefit of medical advice or diagnosis would call mental disorder or illness. *See Brewer v. Lincoln Nat. Life Ins. Co.*, 921 F.2d 150, 154 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238, 111 S. Ct. 2872, 115 L. Ed. 2d 1088 (1991) (applying a mental illness limitation in an ERISA policy to deny

benefits, despite expert evidence that participant suffered from affective mood disorder caused genetically or biologically, because "laypersons are inclined to focus on the symptoms of an illness; illnesses whose primary symptoms are depression, mood swings and unusual behavior are commonly characterized as mental illnesses regardless of their cause. . . . Regardless of the cause of his disorder, it is abundantly clear that he suffered from what laypersons would consider to be a 'mental illness' "). Several caveats must be added regarding the *Brewer case*, however. It is one of the few ERISA cases in which a court has rejected the contra proferentem rule; consequently, the *Brewer* court did not construe the limitation strictly against the insurer or consider any other viewpoint than that of an ill read layperson having no expert medical advice about the particular patient in question. Also, without further refinement, the *Brewer* definition of mental illness would apply to, inter alia, an accident victim who exhibits abnormal behavior as the result of a traumatic head injury, a person suffering from brain cancer who develops unusual behavior, an elderly person who has contracted Alzheimer's Disease, and a delirious person suffering from a high fever caused by a staph infection. *See Phillips v. Lincoln Nat. Life Ins. Co.*, 978 F.2d 302, 306 at n.2. Moreover, the Eight [sic] Circuit subsequently partially retrenched from *Brewer* by applying contra proferentem in the ERISA context when an ambiguity cannot be resolved by interpreting the language as would an average plan participant. *Delk v. Durham Life Ins. Co.*, 959 F.2d 104, 105-106 (8th Cir. 1992).

Another somewhat reasonable interpretation of such terms as mental or psychiatric disorder focuses

on neither the cause nor symptoms of a psychiatric condition, but on the nature of the treatment involved. *See Simons v. Blue Cross & Blue Shield of Greater New York*, 144 S.D.2d 28, 536 N.Y.S.2d 431 (N.Y. App. Div. 1989) (hospitalization for treatment of malnutrition due to anorexia nervosa was not subject to the limitation of coverage applicable to in-hospital care for psychiatric disorders; regardless of whether anorexia nervosa was a mental illness or psychiatric disorder, the purpose of hospitalization was to treat the physical aspects of malnutrition and hypotension, including naso-gastric feeding and medication — thus the hospitalizations were medical treatment, not psychiatric care).

Both the manifestation/symptom and the nature of treatment approaches, reflected in cases such as *Brewer* and *Simons*, have been criticized by commentators as flawed methods of analyzing whether a particular mental illness should be subject to insurance coverage limits or exclusions. Before the development of brain research, reasonably intelligent persons could reach a broad consensus on what was a mental or physical disorder. Steven P. Garmisa, "*Mental Illness*" *Limitation in Health Insurance Policies*, Chicago Daily Law Bulletin, Nov. 6, 1990 at 2. However, because of medical findings that serious illnesses once considered purely mental, such as schizophrenia, bipolar affective disorder, and depressive illness are physical brain diseases, reasonable persons can disagree sharply on the meaning of "mental or nervous disorder." The average layperson's understanding should be constantly changing with advances in medical research. As the public learns more about the actual

> causes and treatments for mental illness, it follows that the average layperson's understanding of terms such as "mental illness" and "psychiatric treatment" will change as well. Brian D. Shannon, *The Brain Gets Sick, Too — The Case For Equal Insurance Coverage For Serious Mental Illness*, 24 St. Mary's L.J. 365, 370-382 (1993).

Id. at 986-988.

> My colleagues in the majority have fallen into error in affirming the trial court's result because they likewise failed to perform a *de novo* review[2] of the policy and its limitation provision and because they failed to follow the precedents of this Circuit which require the application of the rule of contra proferentem. If they had not lapsed in these respects they surely would have recognized that the limitation clause is ambiguous, construed it strictly against the insurer, realized that under the reasonable interpretation that as most favorable to Lynd there is a genuine dispute as to a material fact and that Reliance is not entitled to judgment as a matter of law, and would have reversed the summary judgment and remanded the case for trial or further proceedings.

Id. at 989.

The Seventh Circuit in *Phillips v. Lincoln National Life Ins. Co.*, 978 F.2d 302, 310 (C.A.7, 1992), has ruled that the undefined phrase "mental illness" in an ERISA policy is ambiguous:

> Faced with these competing definitions of "mental illness" which have divided not only the litigants but

2. In the present case, the review was *de novo*.

also federal and state courts, we have no trouble agreeing with the district court's finding that the term "mental illness" as used in the Plan is ambiguous. As in **Kunin**, where the Ninth Circuit found the term "mental illness" in a welfare benefit plan ambiguous, here the Plan

> **contains no definition or explanation of the term "mental illness," and offers no illustration of the conditions that are included or excluded. Nor does the policy contain any language suggesting whether the cause or the manifestation [of an illness] determines whether an illness is covered. . . .**

910 F.2d at 541. We thus hold that the Plan term "mental illness" is ambiguous as applied to individuals like James who have mental disorders caused by organic illnesses.

The Ninth Circuit in *Kunin v. Benefit Trust Life Insurance Co.*, 910 F.2d 534, 541 (C.A.9 1989), also held the phrase ambiguous:

> Insurance contracts generally spell out in inordinate detail the meaning of terms that lack a fixed meaning. Great efforts are ordinarily made to eliminate the natural ambiguity that exists in so many of the words and phrases we use daily. In this policy, however, Benefit Trust made no attempt whatsoever to describe the scope of a term that has no precise or generally accepted definition. Under these circumstances, we conclude that the term "mental illness" is ambiguous.

In *Lang v. Long Term Disability Plan*, 125 F.3d 794, 799 (C.A.9 1997), the Ninth Circuit ruled that "mental disorder" was ambiguous:

> The two-year limitation in the Plan relates to disabilities "caused or contributed to" by a **"mental disorder."** Lang contends that because the record reflects that her disability was caused by a physical illness, fibromyalgia, the limitation does not apply. In its February 24 letter, however, Standard interpreted the term as referring to symptoms, and not to causes. The Plan language presents an almost classic ambiguity. *See Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534 (9th Cir. 1990); *Phillips v. Lincoln Nat. Life Ins. Co.*, 978 F.2d 302 (7th Cir. 1992). Both Kunin and Phillips considered a similar phrase, "mental illness," and held that it was ambiguous in that it could reasonably refer either to illnesses with physical causes, but exhibiting both physical and non-physical symptoms.

Since *de novo* review was utilized, the administrator/ insurance company had no discretion to interpret the plan:

> We apply the *Firestone* range of standards to interpretations of ambiguous plan provisions. *Brown v. Blue Cross & Blue Shield*, 898 F.2d 1556-68 (11th Cir. 1990); *Newell v. Prudential Ins. Co. of Am.*, 904 F.2d 644, 650 (11th Cir. 1990). Acknowledging the standards of review set forth in *Firestone*, this Court in *Brown* crafted an additional, more stringent standard of review for circumstances where the decisionmaker suffers a conflict of interest. *Brown*, 898 F.2d at 1566; *Newell*, 904 F.2d at 651. Therefore, we have three standards of review for plan

> interpretations: (1) *de novo*, applicable where the plan administrator is not afforded discretion; (2) arbitrary and capricious where the plan administrator possesses discretion; and (3) heightened arbitrary and capricious where there is a conflict of interest.

Marecek v. BellSouth Services, Inc., 49 F.3d 702, 705 (11th Cir. 1995).

> Alabama strictly construes ambiguities against insurers.
>
> We begin by noting that insurance contracts are subject to the same general rules applicable to other written contracts; specifically, in case of doubt or uncertainty as to a policy's meaning, the terms of the policy are to be interpreted against the party that drafted them. *Home Indemnity Co. v. Employers National Insurance Corp.*, 564 So.2d 945 (Ala. 1990). If the policy is clear and unambiguous in its terms, then there is no question of interpretation or construction. *Home Indemnity*. If the policy is unclear and ambiguous in its terms, but not void for uncertainty, then it must be interpreted and construed under well-settled rules of construction applicable to all contracts. It is the province of the court, not the jury, after duly considering the whole of the policy, to determine if it is uncertain or ambiguous in its terms.

American and Foreign Ins. Co. v. Tee Jays Manufacturing Co., Inc., Tee Jays Holding Corporation, 1997 WL 187099 (Ala. 1997).

A BREACH OF FIDUCIARY DUTY CLAIM UNDER ERISA IS NOT PRECLUDED IF ANOTHER VIABLE ERISA CLAIM EXISTS.

The District Judge did not respond to or acknowledge Plaintiff's breach of fiduciary duty claim. The Eleventh Circuit Court of Appeals ruled that the District Judge was not required to rule on the claim. The District Judge's refusal to rule was explained in *Short v. American Cast Iron Pipe Co.*, 961 F. Supp. 261, 266, where he stated that a breach of fiduciary duty claim does not exist if another viable ERISA claim exists:

> . . . Thus § 502(a)(1)(B) allows him to recover any benefits he is due under the plan, and relief under § 502(a)(3) is not appropriate.
>
> . . . . .
>
> . . . To trigger recovery under § 502(a)(3), the ERISA statute must, as in *Varity*, fail to remedy all of the wrongs that were done to plaintiff. *Varity*, __U.S. at __, 116 S. Ct. at 1079; *Forsyth v. Humana, Inc.*, 99 F.3d 1504, 1511 (9th Cir. 1996); *Wald v. Southwestern Bell Corporation Customcare Medical Plan*, 83 F.3d 1002, 1006 (8th Cir. 1996).
>
> Congress provided plaintiff with an adequate remedy in § 502(a)(1)(B). Thus recovery under § 502(a)(3) is not warranted in this case.

The case of *Varity* does not hold that a breach of fiduciary duty claim is precluded by a viable ERISA claim. *Varity* established the validity of fiduciary duty claims and did not limit them to a "last resort" if no other ERISA claim existed.

Judge Lynne relied on the Ninth Circuit decision of *Forsyth v. Humana, Inc.*, 99 F.3d 1504, 1511 (C.A.9 1996), which stated:

> In *Varity Corp.* the Court emphasized that section 1132(a)(3) is a "catchall" provision which provides relief only for injuries that are not otherwise adequately provided for. __ U.S. at __, 116 S. Ct. at 1078.
>
> > Thus, we should expect that where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be "appropriate."
>
> The Supreme Court thus interpreted the statute to allow individual relief for a breach of fiduciary duty in an ERISA action only where no other adequate relief is available.

He also relied upon the Eighth Circuit decision of *Wald v. Southwestern Bell Corp.*, 83 F.3d 1002, 1006 (C.A.8 1996), wherein the court stated:

> The Court also noted that section 502(a)(3) authorizes only "appropriate" equitable relief. The Court stated that "where Congress elsewhere provided adequate relief for a beneficiary's injury, there will likely be no need for further equitable relief, in which case such relief normally would not be 'appropriate.' " *Id.* at __, 116 S. Ct. at 1079. Because Wald is provided adequate relief by her right to bring a claim for benefits under section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), as she did

> in Count I, and she seeks no different relief in Count II of her complaint, equitable relief would not be appropriate in her case. Thus, she does not have a cause of action under section 502(a)(3).

The Eighth, Ninth and Eleventh Circuits have unduly limited breach of fiduciary duty claims as allowed by ERISA.

Such a rule would be fundamentally unfair because the breach of fiduciary duty often jeopardizes the claimant's ability to present his claim. Thus, a claimant may be denied benefits. However, if the fiduciary duty had not been breached, benefits would have been awarded. In such a situation, the benefit claim is not a "viable claim" and should not preclude a breach of fiduciary duty claim.

CONCLUSION

WHEREFORE, Petitioner submits that her petition should be granted because "mental disorder" is ambiguous as a matter of law under the circumstances of this case. Also, the breach of fiduciary duty claim should not be precluded because Petitioner had another legal remedy which failed due to the breach of fiduciary duty.

Respectfully submitted,

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APPENDIX

APPENDIX A — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT FILED JANUARY 9, 1998

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

NO. 97-6269

District Court Docket
No. CV-96-L-1810-M

TERESA KILLIAN

Plaintiff-Appellant

v.

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY,

Defendant-Appellee

SOUTHERN COMPANY SERVICES, THE

Defendant.

Appeal from the United States District Court
for the Northern District of Alabama

(January 9, 1998)

Before HATCHETT, Chief Judge, FAY, Circuit Judge, and FARRIS*, Senior Circuit Judge.

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* Honorable Jerome Farris, Senior U.S. Circuit Judge for the Ninth Circuit; sitting by designation.

Appendix A

FARRRIS, Senior Circuit Judge:

Teresa Killian's long term disability benefits were terminated by Provident Life and Accident. The insurer concluded that Killian had failed to present sufficient evidence of a continuing disability. The district court upheld the termination. Killian appeals on four grounds: that the district court 1) incorrectly limited review to facts available to the administrator at the time of termination of benefits; 2) failed to recognize ambiguity in the plan's terms; 3) that the administrator's construction of the plan's terms violates the ADA; and 4) that the insurance company breached its fiduciary duty when it called for an independent medical evaluation and ultimately terminated her benefits. We affirm.

BACKGROUND

Teresa Killian was employed as a technical writer at Southern Company Services. She began collecting long term disability benefits through Southern's health plan in September 1993 after suffering complications with a pregnancy. The Long Term Disability Plan provided that Killian would receive benefits for up to two years for any disability that prevented her from performing each and every duty of her job. Benefits were to continue after the two-year period only if Killian was unable to engage in any occupation for which she was reasonably qualified by training, education, and experience. Further, the plan provided that, for disabilities caused by mental or nervous disorders, benefits would be paid for only two years.

While Killian was receiving benefits, Provident Life and Accident assumed administration of the long term disability plan. After reviewing Ms. Killian's case, Provident concluded that it would need further documentation of Killian's continuing

disability. Provident mailed a letter to Killian's treating physician. The physician failed to respond. Provident then authorized an evaluation of Killian by Dr. Kulback, an independent, board-certified doctor who was hired through a medical appointment service. Provident enlisted the appointment service but played no part in selecting Dr. Kulback.

Dr. Kulback found that, although Killian seemed emotionally troubled, there were "no physical reasons why she would be unable to return to work on at least a limited basis in a job that did not require more than moderate physical activity." Following this finding, a rehabilitation consultant at Provident evaluated Killian's education, training, and experience and determined that there were jobs that Killian could perform. The consultant recommended terminating Killian's benefits. A copy of his report was sent to Killian's physician of record. There was no response. In March 1996, after having paid benefits for 2½ years, Provident terminated benefits.

Killian wrote to Provident appealing the decision. While preparing its response, Provident was served with the complaint in this action. Killian promptly consulted her own doctor, Dr. Mason, for an evaluation. Dr. Mason wrote a report summarizing her evaluation but allowed Killian to edit the report to exclude the words "physical and psychological conditions." This report was later presented to the district court as evidence of Ms. Killian's condition.

Dr. Mason had diagnosed Ms. Killian with a somatization/ conversion disorder. At a bench trial in district court, Dr. Mason described somatization disorder as "the tendency of a person to translate emotional or mental stress . . . into clear cut physical symptoms, symptoms below the neck." Conversion disorder,

according to Killian's doctor, "is a psychiatric disorder . . . in which a patient manifests a physical disorder for which no physical cause can be found." The district court entered findings of fact and law as well as judgment for Provident. Killian appeals.

STANDARD OF REVIEW

In an ERISA case, we review conclusions of law de novo but do not disturb findings of fact unless they are clearly erroneous. *Godfrey v. Bellsouth Telecommunications, Inc.*, 89 F.3d 755, 757 (11th Cir. 1996). The district court must review an administrator's plan interpretation under one of three possible standards of review: 1) de novo, where the plan does not grant the administrator discretion; 2) arbitrary and capricious, where the plan grants the administrator discretion; or 3) heightened arbitrary capricious, where there is a conflict of interest. *Maracek v. Bellsouth Telecommunications, Inc.*, 49 F.3d 702, 705 (11th Cir. 1995). Provident's plan did not grant the administrator any discretion. The district court properly employed the de novo standard.

DISCUSSION

The initial question is whether the district court *actually considered* evidence presented by Killian after the administrator's termination of benefits. Killian claims that the district court wrongly refused to consider any facts provided by her after the administrator's determination. In support of this argument, she points to Paragraph 16 of the district courts findings of fact:

> 16. The termination of plaintiffs benefits was based on all medical information then available to defendants.

Appendix A

> This included the report from Dr. Kulback as well as all the information that had been available in August 1994 when benefits were first extended to plaintiff. *Plaintiff failed to supply any other medical information to defendants.*

ER 28-6 (emphasis added).

Killian claims that the final sentence indicates that the district court failed to consider as evidence, among other things, the post-termination medical reports written by Dr. Mason. But Killian misconstrues this finding. The final sentence of Paragraph 16 concludes only that no further evidence was ever presented to Provident. It is silent on the question of whether Killian presented any post-termination evidence to the district court.

Not every piece of evidence was incorporated into the district court's findings of fact. Moreover, the district court did not formally *exclude* any of the post-termination evidence provided by Killian. Dr. Mason's testimony, for example, was resented to the district court and nothing in the record suggests that it was not considered. A more likely explanation for its exclusion from the findings of fact is that the district court did not find any of Killian's post-termination evidence credible. Dr. Mason's post termination report had been edited by Killian so as to delete a reference to "physical and psychological disorders." The fact that a patient made an editorial change to a medical report of her own condition is sufficient to warrant the district court's skepticism. Even more troubling, Killian knew at the time of making that editorial change that any reference to a psychological disorder might lead to the termination of her benefits under the "mental and nervous disorder" limitation of

the plan. These circumstances may explain why the district court did not refer to it in its findings of fact. Killian's claim that the district court improperly limited its review finds no support in the record.

Even if Killian had adequately proven her disability, her benefits would still have been properly terminated subject to the plan's two-year limitation on "mental and nervous disorders." ER-28-7. Killian argues, however, that this limitation is ambiguous because "mental and nervous disorders" are never defined anywhere in the plan. It is unclear, she claims, whether a disorder with a mental origin but physical symptoms, such as her somatization/conversion disorder, falls within the two-year limitation. Had the district court properly recognized this ambiguity, Killian argues, it would have been forced to resolve the ambiguity in her (the insured's) favor.

Lynd v. Reliance Standard Life Ins. Co., 94 F.3d 979 (5th Cir. 1996) is instructive. *Lynd* held that qualifying phrases such as "'mental or nervous disorders' used in ERISA plans . . . should be accorded their ordinary, lay meanings." *Id.* at 983 (quoting *Brewer v. Lincoln National Life Ins.* Co., 921 F.2d 150, 154 (8th Cir. 1990). The Fifth Circuit reasoned that ERISA language is targeted to laypersons, not medical experts. We agree. The terms used to explain benefit limitations should be read through the lens of a layperson assessing the origin of an illness. There is no ambiguity.

Killian's disability is best classified as a "mental or nervous disorder." To hold that Killian's disability falls outside of the term "mental disorder" because it has "physical" symptoms would render the term "mental disorder" obsolete in this context. *Lynd*, 94 F.3d at 984. Provident cannot have intended for the

two-year limitation to reach "only those [mental] illnesses, if there are any, which have no physical manifestations." *Id.* The fact that Killian's psychological disorder necessarily includes physical symptoms cannot render the disability a physical one rather than a mental one. Killian's entitlement to benefits had already lapsed by the time Provident notified her of the termination.

Killian argues that Provident's construction of the Long Term Disability plan violates the Americans with Disabilities Act. At oral argument counsel recognized, as he must, that the nondiscrimination provisions of the ADA do not "govern the content of a long-term disability policy offered by an employer." *Parker v. Metropolitan Life Ins. Co.*, 121 F.3d 1006, 1012 (6th Cir. 1997). (concluding that ADA does not address contents of long-term disability plans offered by employer because such plans have no reference to a place of public accommodation)

We also note that Killian testified that she still fulfills all of her obligations at home as a mother to her children. Presumably, her inability to work is the major life activity that has been impaired, according to Killian. But an impairment does not substantially limit the ability to work, for the purposes of the ADA, "merely because it prevents a person from performing either a particularized job or a narrow range of jobs." *Stewart v. Happy Herman's Cheshire Bridge. Inc.*, 117 F.3d 1278 (11th Cir. 1997). According to Dr. Kulback, Killian's impairment merely requires her to keep a rather sedentary job, which is in line with her education and training as a technical writer. Arguably, this impairment does not restrict Killian's ability to work to a sufficient degree to render her disabled for the purposes of the ADA.

Killian's final claim is that Provident breached its fiduciary duty to her when it ordered an independent examination of her

condition and terminated her benefits. The district court's conclusion that the administrator's termination of benefits was proper made it unnecessary for it to reach Killian's fiduciary duty claim. We therefore are left to rely solely upon the two pages of Killian's brief where she argues, but offers nothing to even suggest, that Provident breached its fiduciary duty under ERISA and *Varity Corp. v. Howe*, 116 S.Ct. 1065 (1996).

In *Varity,* the Supreme Court concluded that a plan administrator was acting as a fiduciary when he made representations and offered advice to employees about transferring their benefits. *Id.* at 1072-72. Provident never made representations or offered advice to Killian about the status of her benefits. Provident merely invoked one of the provisions of the plan that gave it the right to evaluate Killian's condition to ensure that she still qualified for benefits under the plan.

Nothing in the record would support a finding of a breach of fiduciary duty.

AFFIRMED.

APPENDIX B — JUDGMENT OF THE UNITED STATES DISTRICT COURT, NORTHERN DISTRICT OF ALABAMA, MIDDLE DIVISION, FILED FEBRUARY 21, 1997

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
MIDDLE DIVISION

CV 96-L-1810-M

TERESA KILLIAN,

Plaintiff,

vs.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY; SOUTHERN COMPANY SERVICES, INC.,

Defendant.

JUDGMENT

In accordance with the findings of fact and conclusions of law entered contemporaneously hereto,

It is hereby ORDERED, ADJUDGED and DECREED that plaintiff take nothing and that the action be dismissed on the merits, with each party to bear their own costs.

DONE this 21st day of February 1997.

s/ Seybourn H. Lynne
SENIOR JUDGE

APPENDIX C — FINDINGS OF FACT AND CONCLUSIONS OF LAW FILED FEBRUARY 21, 1997

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
MIDDLE DIVISION

CV 96-L-1810-M

TERESA KILLIAN,

Plaintiff,

vs.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY; SOUTHERN COMPANY SERVICES, INC.,

Defendants.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This cause came on for trial before this court, without the intervention of a jury, on February 5, 1997, upon the pleadings, the order of pretrial conference, the evidence and exhibits, and the arguments of counsel. The court enters the following findings of fact and conclusions of law:

Findings of Fact

1. Plaintiff Teresa Killian was an employee of Southern Company Services, Inc. ("SCS") beginning January 13, 1986. While employed there, she was covered under the SCS Long-Term Disability Plan. The version of the plan at issue in this case became effective on January 1, 1990.

Appendix C

2. The plan provides that when a claim for benefits is made, the plan's administrator would first decide whether the claim was due to be granted. Within sixty days of the denial of any claim by the administrator, the claimant could appeal this decision to a committee appointed by SCS. The plan states that this committee has the power to interpret the plan and to decide any disputes which might arise regarding benefit eligibility.

3. The plan provides that a participant would make a claim for benefits by submitting written proof of the claim to the committee. The committee may, at any reasonable time, require a participant to furnish certification by a physician in support of the claim;

4. The plan provides that disability benefits would be paid for up to two years for a disability that prevented an employee from performing each and every duty of his or her job. Benefits would continue after this two-year period only if he or she was unable to engage in any occupation for which the employee was reasonably qualified by training, education, and experience. Further, the plan provides that for disabilities caused by mental or nervous disorders, benefits would be paid only for two years.

5. In April and May of 1993, plaintiff was diagnosed with rheumatic mitral valve disease of the heart.

6. Plaintiff applied for long-term disability benefits under the SCS plan. On December 9, 1993, plaintiff was informed that her application for long-term disability benefits had been denied. Plaintiff appealed this determination. On August 26, 1994, plaintiff's long-term disability benefits were reinstated by the committee. Defendants paid plaintiff retroactively, as if she had actually begun receiving benefits on September 13, 1993.

Appendix C

7. The August 26, 1994 letter to plaintiff stated that, as plaintiff claimed to be suffering from a mental or nervous disability, her benefits would be limited to a twenty-four month period. On September 12, 1994, plaintiff's attorney wrote defendants and informed them that plaintiff believed she was suffering from a physical, rather than a mental or nervous, disability.

8. At the time that the committee determined plaintiff was to be paid benefits, it made that determination based on the medical information then available to it. The committee was aware that plaintiff had received surgery to remedy her mitral valve disease. It was aware that Dr. Mark Middlebrooks was treating plaintiff for a staph infection. It was aware that, in a consultation with Dr. Vance Plumb, plaintiff stated that she was depressed but was afraid that seeing a psychiatrist would endanger her employment. It was aware that plaintiff's attending physician, Dr. Beverly Warren-Lynch, had diagnosed plaintiff with rheumatic heart disease, pleuritic chest pain, seizures, and depression. It was aware that Dr. Alan Blotcky, a psychologist, had stated that plaintiff's clinical depression, chronic anxiety, and dependent personality disorder would cause her marked difficulties in a work environment. It was aware that Dr. Irwin Lewis had diagnosed plaintiff with sinus headaches. It was aware that plaintiff had told Dr. Frederic Feist that she had previously experienced suicidal tendencies, and that she believed her depression and anxiety disorder would prevent her from holding gainful employment.

9. On March 1, 1995, Provident Life and Accident Insurance Company ("Provident") became the plan administrator of the SCS Long-Term Disability Plan. On that same day Provident and SCS entered into an agreement of reinsurance under which Provident would reinsure all of SCS's liabilities for benefit payments that

arose prior to that date. Thus Provident undertook responsibility paying plaintiff's future benefits.

10. Under the Reinsurance Agreement, Provident was given authority to decide whether preexisting claims for benefits would continue.

11. Beginning July 31, 1995 and continuing for more than six months, Provident made repeated attempts to obtain current medical advice from plaintiff's attending physician, Dr. Warren-Lynch. These attempts were unsuccessful.

12. On November 2, 1995, Provident informed plaintiff that it wished to exercise the provision of the SCS Long-Term Disability Plan allowing for a physical examination by someone other than plaintiff's attending physician. Professional Appointment Services was hired to select a board-certified internist. Although she protested, plaintiff did indeed see Dr. Steven Kulback.

13. Dr. Kulback determined that plaintiff was able to perform some occupations for which she was reasonably qualified. In making this determination, Dr. Kulback noted that plaintiff had a medical history that included seizures, migraine headaches, mitral regurgitation, ulcers, bronchitis sinusitis, staph infections, and depression. He stated in his December 1, 1995 report, "I did nor find any physical reasons why [plaintiff] would be unable to return to work on at least a limited basis in a job that did not require more than moderate physical activity. She does not appear to be eager to return to work, and in her correspondence with the insurance company and with physicians she reiterates many reasons why she should not return to work. . . . However, the cumulative effect of these [physical]

problems has certainly affected her psychologically, and it is certainly possible that her mental health status may prevent her from returning to gainful employment."

14. On March 31, 1996, Provident informed plaintiff that, effective that day, plaintiffs long-term disability benefits were terminated. In the letter to plaintiff, Provident noted that available medical evidence indicated that she not disabled from any occupation for which she was reasonably qualified, and Provident noted that there was a two-year limit on disabilities caused by a mental or nervous disorder.

15. On April 7, 1996, plaintiff wrote Provident questioning the termination of her benefits. Provident interpreted plaintiff's April 7, 1996 letter as an appeal of the denial of benefits. On May 8, 1996, Provident informed plaintiff that the committee had denied her appeal because she had failed to provide medical evidence that she qualified for disability benefits.

16. The termination of plaintiff's benefits was based on all medical information then available to defendants. This included the report from Dr. Kulback as well as all the information that had been available in August 1994 when benefits were first extended to plaintiff. Plaintiff failed to supply any other medical information to defendants.

17. In July 1996, plaintiff first saw Dr. Anne Mason, who had taken over Dr. Warren-Lynch's practice. She has diagnosed plaintiff as suffering from somatization disorder, which is the tendency of translating emotional stresses into clear physical symptoms.

Appendix C

Conclusions of Law

1. This court has jurisdiction of this action and of the parties thereto.

2. The SCS Long-Term Disability Plan is an employee welfare benefit plan maintained by SCS for the purpose of providing the participants with disability benefits. 29 U.S.C. § 1002(1). This employee welfare benefit plan is also an employee benefit plan, 29 U.S.C. § 1002(3), and as such it is subject to the provisions found in the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*

3. Under a *de novo* standard of review, defendants's termination of plaintiff's long-term disability benefits is not due to be overturned. Under a *de novo* standard, the court focuses on the terms of the plan and other manifestations of the partes' intent. *Firestone Tire and Rubber v. Bruch*, 489 U.S. 101, 112-13 (1989); *Bedinghaus v. Modern Graphic Arts,* 15 F.3d 1027, 1029 (11th Cir. 1994), *cert. denied*, 115 S. Ct. 426 (1994). Where disputed terms are without ambiguity, the court presumes that the natural meaning of the terms is conclusive evidence of the intent of the parties. *Bedinghaus*, 15 F.3d at 1029.

4. Under the clear terms of the plan, plaintiff's benefits were due to be ended on September 13, 1995 (two years after they began) because her disability resulted from a mental or nervous disorder. Further, all available medical evidence indicates that there was no physical reason why plaintiff would have been unable to engage in an occupation for which she was reasonably qualified.

5. (Plaintiff has failed carry out her duty under the plan of furnishing certification by a physician that there was a physical reason for her disability, and has failed to show that she was unable to engage in an occupation for which she was reasonably qualified. Thus plaintiff has failed to propose any set of facts allowing her to be covered under a reasonable interpretation of this plan. *Florence Nightingale Nursing Service, Inc. v. Blue Cross and Blue Shield of Alabama*, 41 F.3d 1476, 1481 (11th Cir. 1995), *cert. denied*, 115 S. Ct. 2002 (1995); *Brown v. Blue Cross and Blue Shield of Alabama*, 898 F.2d 1556, 1567 (11th cir. 1990), *cert. denied*, 498 U.S. 1040 (1991).

6. Because the termination of plaintiff's long-term disability benefits satisfies the *de novo* standard of review, the court need not pass on which standard of review applies to this claim. *See Marecek v. BellSouth Telecommunications*, 49 F. 3d 702, 705 (11th Cir. 1995); *Brown*, 898 F.2d at 1567.

DONE this 21st day of February 1997.

s/ Seybourn H. Lynne
SENIOR JUDGE

APPENDIX D — OPINION OF THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT FILED FEBRUARY 25, 1998

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 97-6269

TERESA KILLIAN,

Plaintiff-Appellant,

versus,

PROVIDENT LIFE & ACCIDENT INSURANCE COMPANY,

Defendant-Appellee.

SOUTHERN COMPANY SERVICES, THE,

Defendant.

On Appeal from the United States District Court
for the Northern District of Alabama

BEFORE: HATCHET, Chief Judge, FAY and FARRIS*, Senior Circuit Judges.

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* Honorable Jerome Farris, Senior U.S. Circuit Judge for the Ninth Circuit, sitting by designation.

Appendix D

PER CURIAM:

The petition(s) for rehearing filed by appellant TERESA KILLIAN is denied.

ENTERED FOR THE COURT:

s/ Joseph W. Hatchett
CHIEF JUDGE

APPENDIX E — MOTION FOR NEW TRIAL OR JUDGMENT NOTWITHSTANDING THE VERDICT FILED MARCH 7, 1997

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
MIDDLE DIVISION

CASE NO. CV-96-L-1810-M

TERESA KILLIAN,

Plaintiff,

vs.

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY, SOUTHERN COMPANY SERVICES, INC.

Defendants.

Plaintiff moves that the Court set aside the judgment of 2121/97, and that the Court grant a new trial or a judgment notwithstanding the verdict.

IN SUPPORT, Plaintiff would show as follows:

1. Plaintiff is totally disabled as defined by the LTD policy. She has submitted overwhelming evidence of total disability, and Defendant has **failed to submit substantial evidence** to support the verdict that Plaintiff is not disabled.

In support of her claim for continuing disability benefits, Plaintiff submitted:

Appendix E

(a) Plaintiff's affidavit (Ex. 1) and her trial testimony;

(b) Certification of continuance of disability dated 6/12/95 (Ex. 7);

(c) Letters from Dr. Mihelic and Dr. Pacifico (Ex. 12);

(d) Social Security Determination of Disability (Ex. 12);

(e) Letters and statements from Dr. Vance J. Plumb, Dr. Fredric Feist, Dr. Matthew Mihelic and Dr. Pacifico (Ex. 17);

(f) Letter from Dr. Mason (Ex. 18);

(g) Deposition of Dr. Mihelic;

(h) Deposition of Dr. Feist;

(i) Testimony of Dr. Mason.

2. The Court erroneously held that Plaintiff failed to supply any other medical information to Defendants (Finding of Fact 16). The record shows the following:

(a) *On April 7, 1996, plaintiffs wrote to Provident advising Provident that Dr. Warren-Lynch had been out of the office nine (9) weeks on a medical leave of absence (Ex. 12). Actually, Dr. Warren-Lynch had been out since the first of the year. Plaintiff attached letters from Dr. Mihelic and Dr. Pacifico regarding her condition and a copy of the Social Security decision awarding Social Security disability benefits.* (Plaintiff's Undisputed Fact 18 in Plaintiff's *Trial Memorandum*, see Ex. 12)

Appendix E

(b) *On November 6, 1996, Myron Allenstein provided counsel for Defendant with the following reports:*

a. 10/30/96 - letter from Dr. Vance J. Plumb;

b. 9/27/96 - statement from Dr. Fredric W. Feist w/attached records;

c. 4/4/96 - letter from Dr. Matthew Mihelic of E. Gadsden Clinic;

and

d. 4/23/96 and 10/30/96 - letters from Dr. Pacifico.

(Plaintiff's Undisputed Fact 24 in Plaintiff's *Trial Memorandum*, see Ex. 17)

(c) *On November 20, 1996, Myron Allenstein provided counsel for Defendant a letter from Dr. Mason (Ex. 18) which stated that Plaintiff suffered from active hemorrhagic gastritis, hemorrhagic colitis, ongoing diarrhea, degenerative joint disease in the spine and hips, a positive ANA lab test indicating lupus, depression, anxiety, stress reactions, gastrointestinal problems, and leakage in mitral valve prosthesis. Plaintiff is heavily medicated.* (Plaintiff's Undisputed Fact 25 in Plaintiff's *Trial Memorandum*, see Ex. 18)

(d) The deposition of Dr. Mihelic was taken on January 15, 1997 and Defendant received a copy of said deposition. The deposition was introduced as an exhibit at trial.

(e) Defendant took the deposition of Dr. Fredric Feist on January 30, 1997 and received a copy of the deposition. The deposition was offered as an exhibit at trial.

3. The Court erroneously limited its review of the evidence to the facts available to the administrator at the time of the determination, as shown by Findings of Fact 15 and 16:

> *15. On April 7, 1996, plaintiff wrote Provident questioning the termination of her benefits. Provident interpreted plaintiff's April 7, 1996 letter as an appeal of benefits. On May 8, 1996, Provident informed plaintiff that the committee had denied her appeal because she had failed to provide medical evidence that she qualified for disability benefits.*
>
> *16. The termination of plaintiff's benefits was based on all medical information then available to defendants. This included the report from Dr. Kulback as well as all the information that had been available in August 1994 when benefits were first extended to plaintiff:* ***Plaintiff failed to supply any other medical information to defendants.*** *(Emphasis supplied.)*

A *de novo* review implies a new and full review of all the evidence. The Eleventh Circuit Court of Appeals requires a full review:

> In this circuit, a district court conducting a de novo review of an Administrator's benefits determination is not limited to the facts available to the Administrator at the time of the determination. The district court in this case had before it Kirwan's medical records

A BREACH OF FIDUCIARY DUTY CLAIM UNDER ERISA IS NOT PRECLUDED IF ANOTHER VIABLE ERISA CLAIM EXISTS.

The District Judge did not respond to or acknowledge Petitioner's breach of fiduciary duty claim. The Eleventh Circuit Court of Appeals ruled that the District Judge was not required to rule on the claim. The District Judge's refusal to rule was explained in *Short v. American Cast Iron Pipe Co.*, 961 F. Supp. 261, 266, where he stated that a breach of fiduciary duty claim does not exist if another viable ERISA claim exists:

> . . . Thus § 502(a)(1)(B) allows him to recover any benefits he is due under the plan, and relief under § 502(a)(3) is not appropriate.
>
> . . . . .
>
> . . . To trigger recovery under § 502(a)(3), the ERISA statute must, as in *Varity*, fail to remedy all of the wrongs that were done to plaintiff. *Varity*, __U.S. at __, 116 S. Ct. at 1079; *Forsyth v. Humana, Inc.*, 99 F.3d 1504, 1511 (9th Cir. 1996); *Wald v. Southwestern Bell Corporation Customcare Medical Plan*, 83 F.3d 1002, 1006 (8th Cir. 1996).
>
> Congress provided plaintiff with an adequate remedy in § 502(a)(1)(B). Thus recovery under § 502(a)(3) is not warranted in this case.

The case of *Varity* does not hold that a breach of fiduciary duty claim is precluded by a viable ERISA claim. *Varity* established the validity of fiduciary duty claims and did not limit them to a "last resort" if no other ERISA claim existed.

> disability, among other things, to hold that administrator's denial of benefits was arbitrary and capricious); *Ferguson v. Greyhound Retirement & Disability Trust,* 613 F.Supp. 323 (D.C.Pa. 1985) (relying on Social Security Administration's determination of disability, among other things, to deny defendant's motion for summary judgment).

10 F.3d at 790.

5. The Court failed to consider the ambiguity of the Plan regarding mental and nervous disorders by holding:

> *Under the clear terms of the plan, plaintiff's benefits were due to be ended on September 13, 1995 (two years after they began) because her disability resulted from a mental or nervous disorder.* (Opinion, p. 7)

Plaintiff specifically raised the issue of ambiguity of the Plan in the Trial Memorandum as follows:

> *The LTD Plan regarding mental and emotional disability is ambiguous and the ambiguities should be construed in favor of Plaintiff and against Defendant.* (Plaintiff's Trial Memorandum, p. 5)

Since the Court reviewed the denial of benefits under the *de novo* standard of review, and because there is an ambiguity in the Plan, the Court must accept Plaintiff's sound interpretation of the Plan. Application of the rule of *contra proferentem* is appropriate in resolving ambiguities in insurance contracts

regulated by ERISA. *Lee v. Blue Cross/Blue Shield of Alabama,* 10 F.3d 1547 (11th Cir. 1994) at 1551. Furthermore, if a conflict of interest exists as in the present case, the burden shifts to the administrator to prove its interpretation of the Plan is not tainted by self-interest. *Nightingale v. Blue Cross*, 41 F.3d 1476 (11th Cir. 1995).

The Plan provides:

> *"Special provisions apply to disabilities caused by mental or nervous disorders, alcoholism or drug addiction. Benefits will be paid for a maximum of 24 months except if you are confined in a hospital at the end of that 24 month period, monthly benefits will be payable during the remainder of that confinement."* (Undisputed Fact 26, Ex. 19, p. 8)

Plaintiff's interpretation of said provision is that the two-year limitation does not apply if the mental or nervous disorders are caused by physical problems. It is Plaintiff's position that she is disabled due to physical problems which have caused some mental and nervous disorders. The physical problems are the cause of the disability.

It is noted that in *Marecek v. BellSouth Services. Inc.*, 49 F.3d 702 (11th Cir. 1995), the Eleventh Circuit affirmed the District Court in holding that Plaintiff was disabled due to addiction to pain killing drugs despite the fact that the physician stated plaintiff could return to limited duties. A denial of benefits by the administrator was held to be arbitrary and capricious.

6. The Court did not respond to or resolve Plaintiff's claim that Provident breached it's fiduciary duty to Plaintiff. A claim

for breach of fiduciary duty is contained in Count II of the complaint and is based on *Varity Corporation v. Howe*, 116 S.Ct. 1065 (1996):

> We are not aware of any ERISA-related purpose that denial of a remedy would serve. Rather, we believe that granting a remedy is consistent with the literal language of the statute, the Act's purposes, and pre-existing trust law.

116 S.Ct. at 1079.

7. The Court erred by refusing to allow counsel for Plaintiff to question Dr. Anne Mason about her care and treatment of Plaintiff. Under the *de novo* standard of review, all medical evidence of disability is admissible. *Kirwan v. Marriott Corp.*, 10 F.3d 784 (11th Cir. 1994).

8. The Court construed the LTD policy in a way which violates the Americans With Disabilities Act.

> Statutory language must be given its common and ordinary meaning. *Richards v. United States*, 369 U.S. 1, 9, 82 S.Ct. 585, 590-91, 7 L.Ed.2d 492 (1962). Bearing in mind this important principle, we find that Title III of the Disabilities Act prohibits discrimination on the basis of disability in the contents of insurance products. Insurance products clearly fall within the common and ordinary meaning of the term "goods," and the provision of insurance coverage clearly falls within the common and ordinary meaning of the term "service." In addition, the statute specifically includes "insurance office" within the definition "public

> accommodation" if the entity's operations affect commerce. 42 U.S.C. § 12181(7)(F). The Plaintiff's condition qualifies as a "disability," which is defined as "a physical or mental impairment that substantially limits one or more of the major life activities of such individual." 42 U.S.C.§ 12102(2)(A). Furthermore, because she suffers from a "nervous/mental" (rather than a physical) disability, the Plaintiff is receiving a "good" or "service" that is "different . . . from that provided to other individuals." Thus, the Plaintiff appears to meet the statutory criteria for establishing a claim under Title III of the Disabilities Act.

Parker v. Metropolitan Life Insurance Co., 99 F.3d 181, 187-188 (C.A. 6 1996).

Plaintiff raised this issue in her Trial Memorandum:

> *The two-year provision for mental and emotional disability is in violation of the ADA and the provision must be interpreted in a way so as not to conflict with the ADA. Therefore, there is no two-year limitation.* (Plaintiff's *Trial Memorandum*, p. 4, para. 6)

9. The Court omitted undisputed and essential facts such as the following:

(a) *On 6/12/95, Provident received proof of continuance of disability from Plaintiff and Dr. Warren-Lynch* (Ex. 7) (Plaintiff's Undisputed Fact 11 in Plaintiff's *Trial Memorandum*).

(b) Dr. Warren-Lynch, Plaintiff's treating physician, was unavailable to respond to Provident's inquiries from 1/1/96 to trial date due to a medical leave of absence. (Plaintiff's Undisputed Facts 18, 20, 27 in Plaintiff's *Trial Memorandum*)

(c) Provident first notified Plaintiff of Dr. Warren-Lynch's failure to respond to requests for information by letter of March 7, 1996 which was the termination of benefits letter. (Plaintiff's Undisputed Fact 14 in Plaintiff's *Trial Memorandum*)

(d) On April 7, 1996, Plaintiff wrote Defendant and attached letters from Dr. Mihelic and Dr. Pacifico regarding her condition and a copy of the Social Security decision awarding Social Security disability benefits. (Plaintiff's Undisputed Fact 18 in Plaintiff's *Trial Memorandum*, see Ex. 12)

(e) Myron Allenstein, Plaintiff's attorney, wrote Provident on May 21, 1996, giving notice of suit and requesting reinstatement of benefits. Mr. Allenstein stated that Dr. Warren-Lynch was unable to respond to letters but was expected back in the office in 30 days. (Ex. 14) (Undisputed Fact 20 in Plaintiff's *Trial Memorandum*)

(f) On August 30, 1996, Attorney Allenstein notified counsel for Defendants that Dr. Warren-Lynch had left the practice of medicine and that Plaintiff was in the process of obtaining a statement from Dr. Mason, her new treating physician. (Ex. 16) (Undisputed Fact 23 in Plaintiff's *Trial Memorandum*)

Appendix E

(g) On November 6, 1996, Myron Allenstein provided counsel for Defendant with the following reports:

a. 10/30/96 - letter from Dr. Vance J. Plumb;

b. 9/27/96 - statement from Dr. Fredric W. Feist w/attached records;

c. 4/4/96 - letter from Dr. Matthew Mihelic of E. Gadsden Clinic; and

d. 4/23/96 and 10/30/96 - letters from Dr. Pacifico.

(Ex. 17) (Undisputed Fact 24 in Plaintiff's *Trial Memorandum*)

(h) On November 20, 1996, Myron Allenstein provided counsel for Defendant a letter from Dr. Mason (Ex. 18) which stated that Plaintiff suffered from active hemorrhagic gastritis, hemorrhagic colitis, ongoing diarrhea, degenerative joint disease in the spine and hips, a positive ANA lab test indicating lupus, depression, anxiety, stress reactions, gastrointestinal problems, and leakage in mitral valve prosthesis. Plaintiff is heavily medicated. (Undisputed Fact 25 in Plaintiff's *Trial Memorandum*)

10. The Court made the following erroneous "conclusions of law":

(a) *Under the clear terms of the plan, plaintiff's benefits were due to be ended on September 13, 1995 (two years after they began) because her disability resulted*

> *from a mental or nervous disorder. Further,* ***all available medical evidence indicates*** *that there was no physical reason why plaintiff would have been unable to engage in an occupation for which she was reasonably qualified.* (Conclusion of Law #4, Opinion, p. 7)

This statement is wrong and not supported by the evidence. The terms of the Plan are not clear. Plaintiff's disability resulted from a physical disease. All available medical evidence did not indicate there was no physical reason why Plaintiff would have been unable to engage in an occupation for which she is reasonably qualified. To the contrary, the medical evidence, most of which the Court did not consider because of the mistaken view that it was limited to what the administrator reviewed, clearly supported Plaintiff's claim of continuing total disability.

> (b) *Plaintiff has failed [to] carry out her duty under the plan of furnishing certification by a physician that there was a physical reason for her disability, and has failed to show that she was unable to engage in an occupation for which she was reasonably qualified. Thus plaintiff has failed to propose any set of facts allowing her to be covered under a reasonable interpretation of this plan.* (Conclusion of Law #5, Opinion, p.7)

Plaintiff's treating physician provided certification of disability on 6/12/95 (Undisputed Fact 11 in Plaintiff's *Trial Memorandum*). Thereafter, the treating physician was no longer available for response, and Defendant failed to notify Plaintiff of the doctor's unavailability until Defendant terminated Plaintiff's benefits on 3/7/96 (Undisputed Fact 14 in Plaintiff's *Trial*

Memorandum). Thereafter, Plaintiff submitted ample evidence of disability, and Defendant ignored the evidence.

11. The Court made the following erroneous statement of fact:

> *(a) Although she protested, plaintiff did indeed see Dr. Steven Kulback* (Finding of Fact 12, p. 4 of Opinion)

Plaintiff never protested the examination of Dr. Kulback.

> *(b) In July 1996, plaintiff first saw Dr. Anne Mason, who had taken over Dr. Warren-Lynch's practice. She has diagnosed plaintiff as suffering from somatization disorder, which is the tendency of translating emotional stresses into clear physical symptoms.* (Finding of Fact 17, p. 6 of Opinion)

The Court should have added the following:

> **However, Dr. Anne Mason confirmed that the following physical conditions were supported by objective finding: seizures, degenerative disc and joint disease, mitral regurgitation, ulcers, numerous infections including bronchitis, and chronic gastroenteritis.**

Appendix E

WHEREFORE, the decision should be changed because it is not supported by the record, and because it is contrary to Eleventh Circuit precedent.

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